**Texas Department of Insurance, Division of Workers' Compensation**
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 ● Austin, Texas 78744-1609

## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

| | |
|---|---|
| Requestor's Name and Address:<br><br>Jerome Kosoy, M.D.<br>2900 Weslayan St. 620<br>Houston, Tx 77027 | MFDR Tracking #: M4-08-2182-01<br>DWC Claim #:<br>Injured Empl[redacted] |
| Respondent Name and Box #:<br><br>American Zurich Insurance Co.<br>Rep Box: 19 | Date of Injury<br>Employer Na<br>Insurance Carrier |

### PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary; taken from the Table of Disputed services: "Description of the health care for which payment is in dispute is: Dr. Kosoy was requested to determine the MMI, Return to Work, extent of injury and the disability is a direct result of the work related injury. Requestor's reasoning for why the disputed fees should be paid: The doctor evaluated the examinee and the above issues were addressed."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $550.00
3. CMS 1500(s)
4. EOB's

### PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Carrier maintains that it has paid or will pay all monies owed the provider."

### PART IV: SUMMARY OF FINDINGS

| Date(s) of Service | CPT Code(s) and Calculations | Denial Code(s) | Part V Reference | Amount Due |
|---|---|---|---|---|
| 06/28/07 | 99456-RE | B6, W1/B13 | 1 - 8 | $200.00 |
| 06/28/07 | 99456-59 | B6, W1/B13 | 1 - 8 | $350.00 |
| **Total Due:** | | | | $550.00 |

### PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011 (a-d), titled *Reimbursement Policies and Guidelines,* and Division Rule 134.202, titled *Medical Fee Guideline* effective for professional medical services provided on or after August 1, 2003, set out the reimbursement guidelines.

1. This dispute relates to procedures/services that were billed under procedure code 99456-59 for DOS 06/28/07.

2. This service was initially denied by the Respondent with denial reasons:

- B6 – "This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty."
- W1 – "Workers Compensation State Fee Schedule Adjustment."

3. This service was denied after reconsideration by the Respondent with denial reason:

- B13 -"Previously paid. Payment for this claim/service may have been provided in a previous payment."

4. The provider is a medical doctor; therefore, the Respondent has not supported EOB denial code "B6." The Respondent has not submitted documentation to support duplicate billing and /or payment.
5. According to Rule 134.202(e)(7), "Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a commission or insurance carrier requested RTW/EMC examination that is not for the purpose of certifying MMI and/or assigning an IR (e.g., a medical necessity issue), the examining doctor shall bill and be reimbursed using the "Work related or medical disability examination by other than the treating physician..." CPT code with modifier "RE." The reimbursement shall be $350.00 and shall include commission-required reports. Testing that is required shall be billed using the appropriate CPT code and reimbursed in addition to the examination fee."
6. Advisory 2004-06, issued on May 12, 2004, stated in part that, "A carrier may request a doctor to perform an examination of the injured employee to determine the ability of the injured employee to return to work, to evaluate the medical care of the employee, or both. If the carrier asks, in a single request, for the doctor to both evaluate the medical care and to determine the ability of the injured employee to return to work, the doctor may bill and be reimbursed for each evaluation, both of which occurred in a single examination. In such cases, the doctor may use modifier"59" to indicate that the services performed to complete the carrier's request were distinct or independent, but appropriate under the circumstances."
7. On June 28, 2007, the Division requested that Dr. Kosoy determine the MMI, impairment rating, the ability of the employee to return to work, the employee's compensable injury and whether the employee's disability was a direct result of the work related injury.
8. On this date, the Requestor billed $1700.00 for CPT code 99456 –WP, 99456-RE, 99456-59(X2). Per Division request and submitted reports, the Requestor performed four evaluations. Therefore, Per Rule 134.202(e), the Requestor is entitled to $650.00 + $350.00 + 350.00 + $350.00 = $1700.00. The Respondent paid $1150.00. The Requestor is entitled to additional reimbursement of $550.00.

## PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code Section 134.1, Section 134.202
Texas Government Code, Chapter 2001, Subchapter G
Advisory 2004-06

## PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $550.00 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

**ORDER:**

Authorized Signature

Medical Fee Dispute Resolution Officer

04/16/08
Date

## PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**